		FOR OHF USE					

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038919

Facility Name: Arcola Health Care Center

Address: 422 East Fourth South Street (Number) Arcola (City) 61910 (Zip Code)

County: Douglas

Telephone Number: (217) 268-3022 **Fax #** (217) 268-4180

IDPA ID Number: 371316056001

Date of Initial License for Current Owners: 11/09/93

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Christine A. Hanover **Telephone Number:** 312-634-3400
Altschuler, Melvoin & Glasser LLP
One South Wacker Drive
Chicago, IL 60606-3392
Please send copies of any desk review or audit adjustments to the above address.

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)
(Print Name and Title) _____
(Firm Name & Address) Altschuler, Melvoin & Glasser LLP, One South Wacker Drive, Chicago, Il 60606-3392
(Telephone) (312) 634-3400 Fax # (312) 634-5518

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds n/a

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	100	Intermediate (ICF)	100	36,600	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	100	TOTALS	100	36,600	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	29,958	4,962		34,920	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	29,958	4,962		34,920	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 95.41%

D. How many bed-hold days during this year were paid by Public Aid?
624 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [x] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [x] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 11/09/93

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 11/09/93 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [x] If YES, enter number of beds certified n/a and days of care provided 0

Medicare Intermediary n/a

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/31/00

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7 **	8	9	10	
1	Dietary	109,082	13,596	3,699	126,377		126,377		126,377			1
2	Food Purchase		149,234		149,234		149,234	(2,841)	146,393			2
3	Housekeeping	59,885	12,355		72,240		72,240	6	72,246			3
4	Laundry	41,434	6,874		48,308		48,308		48,308			4
5	Heat and Other Utilities			84,152	84,152		84,152	752	84,904			5
6	Maintenance	40,892	26,742	15,373	83,007		83,007	(1,056)	81,951			6
7	Other (specify):*											7
8	**TOTAL General Services**	251,293	208,801	103,224	563,318		563,318	(3,139)	560,179			8
	B. Health Care and Programs											
9	Medical Director			9,900	9,900		9,900		9,900			9
10	Nursing and Medical Records	715,729	37,144	1,200	754,073		754,073	15	754,088			10
10a	Therapy			105	105		105		105			10a
11	Activities	27,043	2,862	1,922	31,827		31,827		31,827			11
12	Social Services	55,924	2,005	1,166	59,095		59,095		59,095			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	798,696	42,011	14,293	855,000		855,000	15	855,015			16
	C. General Administration											
17	Administrative	198,708		63,034	261,742		261,742	(63,034)	198,708			17
18	Directors Fees											18
19	Professional Services			26,220	26,220		26,220	5,871	32,091			19
20	Dues, Fees, Subscriptions & Promotions			10,784	10,784		10,784	(398)	10,386			20
21	Clerical & General Office Expenses	59,904	6,260	18,476	84,640		84,640	9,261	93,901			21
22	Employee Benefits & Payroll Taxes			151,979	151,979		151,979	14,818	166,797			22
23	Inservice Training & Education			1,108	1,108		1,108	67	1,175			23
24	Travel and Seminar			4,389	4,389		4,389	1,916	6,305			24
25	Other Admin. Staff Transportation			7,319	7,319		7,319	2,538	9,857			25
26	Insurance-Prop.Liab.Malpractice			24,765	24,765		24,765	1,253	26,018			26
27	Other (specify):*											27
28	**TOTAL General Administration**	258,612	6,260	308,074	572,946		572,946	(27,708)	545,238			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,308,601	257,072	425,591	1,991,264		1,991,264	(30,832)	1,960,432			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

**** See schedule of adjustments attached at end of cost report.**

Facility Name & ID Number Arcola Health Care Center #0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7 **	8	9	10	
30	Depreciation			54,760	54,760		54,760	6,687	61,447			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			155,652	155,652		155,652	(36,050)	119,602			32
33	Real Estate Taxes			21,076	21,076		21,076	(2,024)	19,052			33
34	Rent-Facility & Grounds							4,182	4,182			34
35	Rent-Equipment & Vehicles			2,253	2,253		2,253	5,110	7,363			35
36	Other (specify):*											36
37	TOTAL Ownership			233,741	233,741		233,741	(22,095)	211,646			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			54,900	54,900		54,900		54,900			42
43	Other (specify):* Nonallowable costs			26,184	26,184		26,184	(26,184)				43
44	TOTAL Special Cost Centers			81,084	81,084		81,084	(26,184)	54,900			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,308,601	257,072	740,416	2,306,089		2,306,089	(79,111)	2,226,978			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

** See schedule of adjustments attached at end of cost report.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(2,841)	2		4
5	Telephone, TV & Radio in Resident Rooms	(3,469)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(1,209)	30		9
10	Interest and Other Investment Income	(31,915)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest	(4,747)	32		14
15	Non-Care Related Owner's Transactions	(2,024)	33		15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(630)	20		17
18	Fines and Penalties	(81)	43		18
19	Entertainment				19
20	Contributions	(65)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(3,858)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule See Schedule 5A	(21,984)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (72,823)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(6,288)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (6,288)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (79,111)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Arcola Health Care Center

ID# 0038919

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Offset Transportation Income	$ (759)	21	1
2	Offset Vending Machine Income	(13,476)	43	2
3	Offset Miscellaneous Income	(728)	21	3
4	Deferred Maintenance Expensed	1,202	6	4
5	Disallow Miscellaneous Expense	(5,235)	43	5
6	Capitalize Deferred Maintenance	(2,988)	6	6
7				7
8				8
9				9
10				10
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87				87
88				88
89				89
90	**Total**	(21,984)		90

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
James Petersen	100.00%	See Attached Schedule		See Attached Schedule		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	3	Housekeeping	$	Petersen Health Care Companies	100.00%	$ 6	$ 6	1
2	V	5	Utilities		Petersen Health Care Companies	100.00%	752	752	2
3	V	6	Maintenance		Petersen Health Care Companies	100.00%	730	730	3
4	V	10	Nursing		Petersen Health Care Companies	100.00%	15	15	4
5	V	17	Administrative	63,034	Petersen Health Care Companies	100.00%		(63,034)	5
6	V	19	Professional Services		Petersen Health Care Companies	100.00%	5,871	5,871	6
7	V	20	Fees, Subscriptions & Dues		Petersen Health Care Companies	100.00%	232	232	7
8	V	21	Clerical & General Office Exp.		Petersen Health Care Companies	100.00%	10,748	10,748	8
9	V	22	Employee Benefits		Petersen Health Care Companies	100.00%	14,818	14,818	9
10	V	23	Inservice Training & Education		Petersen Health Care Companies	100.00%	67	67	10
11	V	24	Travel & Seminar		Petersen Health Care Companies	100.00%	1,916	1,916	11
12	V	25	Other Admin. Staff Transport.		Petersen Health Care Companies	100.00%	2,538	2,538	12
13	V	26	Insurance		Petersen Health Care Companies	100.00%	1,253	1,253	13
14	Total			$ 63,034			$ 38,946	$ * (24,088)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	30	Depreciation	$	Petersen Health Care Companies	100.00%	$ 7,896	$ 7,896	15
16	V	32	Interest		Petersen Health Care Companies	100.00%	612	612	16
17	V	34	Rent - Facility & Grounds		Petersen Health Care Companies	100.00%	4,182	4,182	17
18	V	35	Rent - Equipment & Vehicles		Petersen Health Care Companies	100.00%	5,110	5,110	18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 17,800	$ * 17,800	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	James Petersen	President	Administrative	100.00%	489,967	7.4	19%	Salary	$ 111,865	L17, C1	1
2	Mark Petersen	Secretary	Administrative	0.00%	186,024	7.4	19%	Salary	42,472	L17, C1	2
3	Todd Petersen	Administration	Administrative	0.00%	68,611	6.3	19%	Salary	15,665	L21, C1	3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 170,002		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Petersen Health Care Companies
Street Address: 7218 North Villa Lake
City / State / Zip Code: Peoria, Illinois 61614
Phone Number: (309) 691-8113
Fax Number: (309) 691-8622

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	3	Housekeeping	Patient Days	187,869	8	$ 30	$	34,920	$ 6	1
2	5	Utilities	Patient Days	187,869	8	4,044		34,920	752	2
3	6	Maintenance	Patient Days	187,869	8	3,925		34,920	730	3
4	10	Nursing	Patient Days	187,869	8	82		34,920	15	4
5	19	Professional Service	Patient Days	187,869	8	31,588		34,920	5,871	5
6	20	Fees, Subscriptions & Dues	Patient Days	187,869	8	1,247		34,920	232	6
7	21	Clerical & General Office Exp.	Patient Days	187,869	8	57,826		34,920	10,748	7
8	22	Employee Benefits	Patient Days	187,869	8	79,721		34,920	14,818	8
9	23	Inservice Training & Education	Patient Days	187,869	8	358		34,920	67	9
10	24	Travel & Seminar	Patient Days	187,869	8	10,309		34,920	1,916	10
11	25	Other Admin. Staff Transport.	Patient Days	187,869	8	13,656		34,920	2,538	11
12	26	Insurance	Patient Days	187,869	8	6,741		34,920	1,253	12
13	30	Depreciation	Patient Days	187,869	8	42,481		34,920	7,896	13
14	32	Interest	Patient Days	187,869	8	3,291		34,920	612	14
15	34	Rent - Facility & Grounds	Patient Days	187,869	8	22,501		34,920	4,182	15
16	35	Rent - Equipment & Vehicles	Patient Days	187,869	8	27,493		34,920	5,110	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 305,293	$		$ 56,746	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	First National Bank-Arcola		x	Mortgage	$15,570.00	07/31/96	$ 1,497,244	$ 1,257,172	05/15/11	0.0900	$ 117,875	1
2	Peoples National Bank		x	Van Loan	$873.00	08/09/98	31,439	6,987	08/13/01	0.0850	1,259	2
3												3
4												4
5												5
	Working Capital											
6	First National Bank-Arcola		x	Line of Credit	varies	05/09/97	270,000	200,000	Demand	0.0850	31,771	6
7												7
8												8
9	TOTAL Facility Related				$16,443.00		$ 1,798,683	$ 1,464,159			$ 150,905	9
	B. Non-Facility Related*											
10	First National Bank-Arcola		x	Mortgage on House	$485.00	05/15/96	62,800	58,430	05/15/11	0.0800	4,747	10
11								Allocated from Home Office			612	11
12								Interest Income Offset			(31,915)	12
13								Disallow Non-Care Interest			(4,747)	13
14	TOTAL Non-Facility Related				$485.00		$ 62,800	$ 58,430			$ (31,303)	14
15	TOTALS (line 9+line14)						$ 1,861,483	$ 1,522,589			$ 119,602	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.		$ 20,465	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	1999	$ 20,770	2
3. Under or (over) accrual (line 2 minus line 1).		$ 305	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 20,771	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.		$	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
	Non-Care Real Estate Taxes	(2,024)	
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 19,052	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	11,626	8
	1996	15,458	9
	1997	18,394	10
	1998	20,465	11
	1999	20,770	12

Accrual is equal to 100% of the 1999 Real Estate Tax Bill of $ 20,770

The Real Estate Tax Expense includes $ 2,024 on non-care asset.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,000 B. General Construction Type: Exterior Brick Frame Wood Number of Stories 1

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [x] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: N/A
2. Number of Years Over Which it is Being Amortized: N/A
3. Current Period Amortization: N/A
4. Dates Incurred: N/A

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility	n/a	1993	$ 44,078	1
2					2
3	TOTALS	n/a		$ 44,078	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	100		1995	1975	$ 859,153	$ 23,159	35	$ 24,547	$ 1,388	$ 135,008	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Building Improvement			1993	13,499		20	675	675	5,062	9
10	Building Improvement			1994	31,000		20	1,550	1,550	10,025	10
11	Building Improvement			1995	10,602	584	20	530	(54)	3,160	11
12	Landscaping			1997	5,593	478	20	280	(198)	980	12
13	Parking Lot			1997	6,500	167	20	325	158	1,138	13
14	Carpeting			1997	934	24	20	47	23	164	14
15	Door Closer			1997	1,225	31	20	61	30	214	15
16	Driveway Grading			1998	784	74	15	52	(22)	130	16
17	Guttering			1998	1,273	33	15	85	52	212	17
18	Wiring			1998	6,426	165	20	321	156	803	18
19	Windows			1998	2,330	60	15	155	95	388	19
20	Siding			1998	12,606	323	20	630	307	1,575	20
21	Doors			1998	765	20	15	51	31	128	21
22	Sink			1998	901	23	20	90	67	225	22
23	Garage			1998	8,286	212	15	552	340	1,380	23
24	Wood Flooring			1999	1,174	11	20	59	48	88	24
25	Asphalt Lot			1999	4,680	25	20	234	209	351	25
26	Tile			1999	6,476	21	20	324	303	486	26
27	Vinyl Siding			1999	5,600	138	25	224	86	336	27
28	Door Alarms			2000	1,593	319	20	40	(279)	40	28
29	Water Heater			2000	5,075	725	20	127	(598)	127	29
30	Sidewalk			2000	876	3	20	22	19	22	30
31	Carpeting			2000	670	2	20	17	15	17	31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 988,021	$ 26,597		$ 30,998	$ 4,401	$ 162,059	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 169,584	$ 20,692	$ 16,254	$ (4,438)	10	$ 74,801	37
38	Current Year Purchases	13,932	2,219	697	(1,522)	10	694	38
39	Fully Depreciated Assets							39
40	Allocated from Home Office			7,896	7,896			40
41	TOTALS	$ 183,516	$ 22,911	$ 24,847	$ 1,936		$ 75,495	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility	1994 Dodge Van	1998	$ 28,010	$ 2,950	$ 5,602	$ 2,652	5	$ 14,005	42
43										43
44										44
45										45
46	TOTALS			$ 28,010	$ 2,950	$ 5,602	$ 2,652		$ 14,005	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 1,243,625	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 52,458	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 61,447	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 8,989	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 251,559	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Land & House	$ 78,850	$ 2,503	$ 11,578	52
53	Vending Machine	3,856	344	3,340	53
54					54
55					55
56					56
57	TOTALS	$ 82,706	$ 2,847	$ 14,918	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: n/a

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6	Allocated from Home Office				4,182			6
7	TOTAL				$ 4,182 **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 7,363 Description: Oxygen Concentrators $216, Copier $2037, Allocated from Home Office $ 5110
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			n/a		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

It is the policy of this facility to only hire certified nurses aides.

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,922	$ 1,922	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance None)	349,580	349,580	3
4	Supply Inventory (priced at cost)	1,654	1,654	4
5	Short-Term Investments			5
6	Prepaid Insurance	52,467	52,467	6
7	Other Prepaid Expenses	840	840	7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): Intercompany Receivable	710,000	710,000	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,116,463	$ 1,116,463	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		44,078	13
14	Buildings, at Historical Cost	1,059,096	988,021	14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	226,958	211,526	16
17	Accumulated Depreciation (book methods)	(304,693)	(251,559)	17
18	Deferred Charges		6,009	18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 981,361	$ 998,075	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,097,824	$ 2,114,538	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 124,466	$ 124,466	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	46,752	46,752	30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,771	20,771	32
33	Accrued Interest Payable	6,752	6,752	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Accrued Insurance	53,324	53,324	36
37	Wage Garnishment	(85)	(85)	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 251,980	$ 251,980	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	206,987	206,987	39
40	Mortgage Payable	1,315,602	1,315,602	40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 1,522,589	$ 1,522,589	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,774,569	$ 1,774,569	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 323,255	$ 339,969	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,097,824	$ 2,114,538	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 218,765	1
2	Restatements (describe):		2
3	**Prior period adjustment Additional Bad Expense**	(46,859)	3
4	**Prior period adjustment 1999 Income Taxes**	(69,580)	4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 102,326	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	220,929	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 220,929	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 323,255	24 *

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,467,484	1
2	Discounts and Allowances for all Levels		2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,467,484	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals	2,841	14
15	Telephone, Television and Radio	2,709	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 5,550	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	31,915	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 31,915	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Schedule 19E	22,069	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 22,069	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,527,018	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	563,318	31
32	Health Care	855,000	32
33	General Administration	572,946	33
	B. Capital Expense		
34	Ownership	233,741	34
	C. Ancillary Expense		
35	Special Cost Centers	26,184	35
36	Provider Participation Fee	54,900	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,306,089	40
41	**Income before Income Taxes (line 30 minus line 40)****	220,929	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 220,929	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return?** No **If not, please attach a reconciliation.**
This entity is a cash basis taxpayer

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.** SEE ACCOUNTANTS' COMPILATION REPORT

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	505	505	$ 14,751	$ 29.21	1
2	Assistant Director of Nursing	2,080	2,080	31,522	15.15	2
3	Registered Nurses	6,978	7,110	105,109	14.78	3
4	Licensed Practical Nurses	14,404	15,058	193,756	12.87	4
5	Nurse Aides & Orderlies	40,348	41,555	351,872	8.47	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	2,004	2,076	18,719	9.02	8
9	Activity Director	1,961	1,961	17,655	9.00	9
10	Activity Assistants	1,451	1,483	9,388	6.33	10
11	Social Service Workers	4,376	4,552	55,924	12.29	11
12	Dietician					12
13	Food Service Supervisor	1,909	1,954	21,744	11.13	13
14	Head Cook					14
15	Cook Helpers/Assistants	14,220	14,676	87,338	5.95	15
16	Dishwashers					16
17	Maintenance Workers	3,882	3,882	40,892	10.53	17
18	Housekeepers	9,567	10,057	59,885	5.95	18
19	Laundry	6,846	7,222	41,434	5.74	19
20	Administrator	2,080	2,080	44,371	21.33	20
21	Assistant Administrator					21
22	Other Administrative	774	774	154,337	199.40	22
23	Office Manager					23
24	Clerical	4,663	4,713	59,904	12.71	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	118,048	121,738	$ 1,308,601 *	$ 10.75	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	92	$ 3,699	L1, C3	35
36	Medical Director	Monthly	9,900	L9, C3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,200	L10, C3	39
40	Physical Therapy Consultant	Monthly	105	L10a, C3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	1,922	L11, C3	44
45	Social Service Consultant	44	1,166	L12, C3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	180	$ 17,992		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses		n/a		51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Karla Schneider	Administrator	0.00%	$ 44,371
James Petersen	Administrative	100.00%	111,865
Mark Petersen	Administrative	0.00%	42,472
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 198,708

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 63,034
TOTAL (agree to Schedule V, line 17, col. 3)	$ 63,034
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
ADP	Payroll Services	$ 7,564
Mid American Programming	Computer Services	1,500
AOL	Computer Services	125
AHCA	Computer Services	1,065
Redline	Computer Services	192
Ginoli & Co.	Accounting	3,814
Altschuler, Melvoin & Glasser LLP	Accounting	3,590
Bush, Snyder & Associates	Legal	2,428
Kingery, Durree, Wakeman & Ryan	Legal	5,942
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 26,220

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 25,534
Unemployment Compensation Insurance	14,530
FICA Taxes	82,936
Employee Health Insurance	22,171
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
401 K Management Fee	2,285
Employee Relations	4,523
Allocated from Home Office	14,818
TOTAL (agree to Schedule V, line 22, col.8)	$ 166,797

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
n/a		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	4,907
Health Care Worker Background Check	
(Indicate # of checks performed 52)	624
Various Licenses	35
Illinois Health Care Association	3,960
Miscellaneous Dues	228
Allocated from Home Office	232
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 10,386

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	1,598
Seminar Expense	2,791
Allocated from Home Office	1,916
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 6,305

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Deferred Maintenance	2000	$ 7,211	3 yrs	$	$	$	$ 1,202	$ 2,404	$ 2,404	$ 1,201	$	$
2													
3													
4													
5													
6													
7													
8													
9													
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16													
17													
18													
19													
20	TOTALS		$ 7,211		$	$	$	$ 1,202	$ 2,404	$ 2,404	$ 1,201	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Arcola Health Care Center # 0038919 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association $3,960**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **n/a**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **10**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **2,475** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **n/a**

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
n/a

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **54,900**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **n/a**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **None** Has any meal income been offset against related costs? **Yes** Indicate the amount. $ **2,841**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **759**
c. What percent of all travel expense relates to transportation of nurses and patients? **None**
d. Have vehicle usage logs been maintained? **n/a**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **n/a**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **n/a**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **n/a**

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: **n/a** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **n/a** If no, please explain. **n/a**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.